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July 7, 2020

Green Mountain Care Board
144 State Street
Montpelier, VT 05602

Re: Blue Cross and Blue Shield of Vermont
Vermont Health Connect 2021 Individual and Small Group Rate Filing
SERFF# BCVT-132371410

The purpose of this letter is to provide a summary and recommendation regarding the proposed 2021 Individual and Small Group Filing for Blue Cross and Blue Shield of Vermont (BCBSVT or Company) and to assist the Green Mountain Care Board (GMCB or Board) in assessing whether to approve, modify, or disapprove the Company's requested rate increase.

FILING DESCRIPTION

1. BCBSVT is a non-profit hospital and medical service corporation that provides health insurance coverage to Vermonters. This filing proposes premiums for BCBSVT's Qualified Health Plans (QHPs) that will be offered on Vermont Health Connect (VHC), beginning January 1, 2021.

2. This filing addresses BCBSVT individual members and small groups. There are approximately 39,200 members[1] enrolled in plans affected by this filing. Enrollment has decreased in recent years, as demonstrated in the following table:

MEMBERSHIP BY COVERAGE YEAR

Coverage Year	Members	Percent Change
2015	67,050	
2016	70,423	5.0%
2017	70,035	-0.6%
2018	53,664	-23.4%
2019	43,939	-18.1%
2020	39,195	-10.8%

[1] L&E uses the term "members" to refer to the number of covered lives. That is, a single policy covering two family members is comprised of two members.

3. As required by law, insurers selling plans on VHC must offer Silver plans with cost-sharing reductions (CSRs) to Vermonters with certain income levels. These members pay a reduced premium that is limited to a specified percentage of their income. These plans include premium funding to offset the loss of federal CSR payments.

   In addition to the Silver plans offered on VHC, in 2019 carriers began offering "Silver Reflective" plans outside of VHC. The Silver Reflective plans do not include CSP premium funding since federal CSR payments do not apply.

   While the VHC Silver plan premiums are substantially higher than the Silver Reflective premiums, most members in these plans will not pay higher premiums because of the federal premium subsidies.

4. The overall impact of this filing is a proposed average rate increase of 6.3%, which is $40.57 on a per member per month (PMPM) basis. This average increase is broken down by plan type in the first table below. The second table illustrates the proposed and approved premium rate changes for the 2020 VHC filing.

2021 PROPOSED RATE CHANGES

Plan Type	Average 2020 Premium PMPM	Average 2021 Premium PMPM	Percent Change	PMPM Change	Percent of Membership
Catastrophic	$264.95	$263.21	-0.7%	-$1.74	1%
Bronze	$500.56	$522.12	4.3%	$21.56	16%
Silver Loaded	$693.58	$732.47	5.6%	$38.89	15%
Silver Reflective	$571.40	$599.40	4.9%	$28.00	20%
Gold	$640.57	$694.88	8.5%	$54.32	28%
Platinum	$796.12	$848.70	6.6%	$52.58	20%
Overall	***$639.18***	***$679.74***	***6.3%***	***$40.57***	***100%***

2020 PROPOSED AND APPROVED RATE CHANGES

Plan Type	Proposed Percent Change	Approved Percent Change	Approved PMPM Change	Percent of Membership
Catastrophic	14.0%	9.1%	$26.33	1.0%
Bronze	13.2%	9.7%	$45.51	14.2%
Silver Loaded	13.9%	10.7%	$66.96	19.9%
Silver Reflective	15.8%	12.5%	$63.84	20.4%
Gold	16.0%	12.9%	$72.56	25.4%
Platinum	17.3%	14.4%	$97.17	19.1%
Overall	***15.6%***	***12.4%***	***$70.90***	***100%***

STANDARD OF REVIEW

Pursuant to *8 V.S.A. §4062*, *18 V.S.A. §9375(6)*, and Green Mountain Care Board *Rule 2.000: Health Insurance Rate Review*, this letter is to assist the Board in determining whether the requested rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the law, and is not excessive, inadequate, or unfairly discriminatory.

SUMMARY OF RECEIVED DATA

BCBSVT provided the methodology used to develop the proposed 2021 individual and small group premiums. The Company provided exhibits which provided the quantitative development for each component of the premium request, including trend, network changes, morbidity adjustments, federal programs, administrative costs, and taxes and fees. The following is a description for several key exhibits.

Exhibit 3 illustrates the development of the proposed pharmacy and medical trend factors.

For medical services trend, the total projected 2019-2021 annualized allowed cost trend is 7.3% per year. The portion applicable to unit cost changes is projected to be 3.6% annually based on recent contracting and provider budgetary changes. The portion applicable to utilization and intensity changes, including the impact of cost containment measures, is projected to be 3.6% annually.

For pharmacy cost trends, the combined utilization for non-specialty drugs was projected and then split into categories to separately model unit cost by category. Due to the relative infrequency and high cost nature of specialty drugs, specialty drugs were analyzed on a PMPM basis rather than separately by utilization and unit costs. The projected allowed cost trend for pharmaceuticals is 13.4%.

Exhibit 5 demonstrates the development of the Market Adjusted Index Rate. Adjustments to the experience period Index Rate were made for population risk morbidity, unit cost trend, utilization trend, non-system claims, market wide adjustments and other factors (such as changes in provider networks).

Exhibit 8 demonstrates the development of expected loss ratios. BCBSVT projects a 2021 traditional loss ratio of 89.1% (including risk adjustment transfer payments) and a 2021 federal Medical Loss Ratio (MLR) of 90.2%, which exceeds the minimum requirement of 80.0%.

Exhibit 9A shows the impact of the single conversion factor which is needed to convert preliminary rates into final rates based on predetermined Vermont tier factors. Exhibit 9B shows the final proposed 2021 premiums, the requested rate increase by plan, and the calculation of the average proposed rate increase of 6.3%.

L&E ANALYSIS

The average proposed 2021 rate increase of 6.3% is attributable to several rating components factors. To create a consistent comparison for both companies filing VHC products, L&E categorized the proposed premium increase reflective of the Unified Rate Review Template (URRT), rather than the distinct rating methodology used by each company.

COMPONENTS OF 2021 PROPOSED RATE INCREASE

Rating Component[2]	Percentage Change[3]	PMPM Change
1. 2019 Actual/Projected Claims Experience	1.9%	$11.65
2. Difference in Trend from 2019 to 2020	0.3%	$1.60
3. Trend from 2020 to 2021	8.9%	$54.60
4. Changes to Population Morbidity Adjustment	1.1%	$6.77
5. Demographic Shift	-2.7%	($16.51)
6. Plan Design Changes	-1.0%	($6.37)
7. Changes to Other Factors	-0.9%	($5.49)
8. Manual Rate Impact	0.0%	$0.00
9. Changes due to Reinsurance	0.0%	$0.00
10. Changes to Risk Adjustment	-1.4%	($8.65)
11. Changes in Exchange User Fees	0.0%	$0.00
12. Changes in Actuarial Value	1.8%	$10.86
13. Changes in Administrative Costs	1.0%	$6.31
14. Changes in Taxes & Fees	-2.4%	($14.49)
15. Changes in Contribution to Reserves	0.2%	$1.37
16. Changes in Single Contract Conversion Factor	-0.2%	($1.09)
Total Proposed Rate Increase	**+6.3%**	**$40.57**

1. **2019 ACTUAL/PROJECTED CLAIMS EXPERIENCE:** Actual 2019 claims experience was 1.9% higher than the 2019 costs expected at the time of the 2020 filing, which was about $11.65 PMPM.[4] Since this change is based on actual claims experience, this rate component appears to be reasonable and appropriate. This impact includes a small increase in risk adjustment receivables, which is discussed in another section.

2. **DIFFERENCE IN TREND FROM 2019 TO 2020:** In the 2020 filed rates, the 2019 to 2020 trend was

[2] The percentages that are attributed to each component may not match the percentages provided by the Company due to the different methodologies between the URRT and the Company's rating approach; therefore, a direct comparison is not appropriate.

[3] The percentage changes are multiplicative and may not sum to the requested 6.3% premium increase.

[4] Filing materials do not always clearly delineate whether morbidity changes are expected to occur in the projection year or interim year. L&E has not attempted to allocate them between the two, and instead assume all morbidity changes occur in the second year of the projection.

projected to be 6.5% for medical and 12.0% for pharmacy. These trends included an explicit adjustment for pharmacy contracting and cost-containment efforts. In the 2021 rate calculation, the 2019 to 2020 medical trend remains at 6.5% overall.

The updated pharmacy trend is 13.4%. The prior combined Medical/Rx 2019 to 2020 trend of 7.3% in last year's filing has been revised upward to 7.7% due to an increase in the Rx trend.

UPDATED 2019 TO 2020 TRENDS

Cost Category	Unit Cost Trend	Utilization / Intensity Trend	Total Allowed Trend	2020 Share of Total Cost
Medical	3.3%	3.1%	6.5%	83%
Pharmacy	10.1%	3.0%	13.4%	17%
Total	***4.5%***	***3.1%***	***7.7%***	***100.0%***

While responding to L&E's inquiries, BCBSVT found an error in the calculation of the weighted average medical trend. BCBSVT noted that the requested increase should have been 6.47%, not the 6.3% proposed in the initial filing. This error correction appears reasonable and appropriate.

The review of the assumptions used in developing the trend projections are discussed further in the next section.

3. TREND FROM 2020 TO 2021: The Company projected an annual allowed trend of 8.9% from 2020 to 2021. This is an increase from the 2019 to 2020 trend of 7.7% that was discussed in the previous section. The breakdown of the 2020 to 2021 trends are outlined below:

2020 TO 2021 TRENDS

Cost Category	Unit Cost Trend	Utilization / Intensity Trend	Total Allowed Trend	2020 Share of Total Cost
Medical	3.8%	4.0%	7.9%	83%
Pharmacy	10.1%	3.0%	13.4%	17%
Total	***4.9%***	***3.8%***	***8.9%***	***100.0%***

MEDICAL TREND: The Company is projecting an annual allowed medical trend of 7.9%, which is comprised of 3.8% for unit cost changes and 4.0% for utilization and intensity changes. When combined with the 2019 to 2020 trends, the result is a total allowed annualized trend of 7.3% from 2019 to 2021. This trend of 7.3% is comprised of 3.6% for unit cost changes and 3.6% for utilization and intensity changes.

MEDICAL UNIT COST TREND

For the BCBSVT service area, the Company analyzed recent changes to provider contracts as the starting point for the 2020 to 2021 unit cost trend estimates. Approximately 53% of medical costs are related to facilities impacted by the Board's Hospital Budget Review process.

BCBSVT took the following approach in setting the 2020 to 2021 unit cost trend assumptions:

GMCB HOSPITAL BUDGET REVIEW

The overall annualized unit cost medical trend of 3.6% includes:

1) a trend of 4.2% for facilities and providers that are impacted by the GMCB's Hospital Budget Review, and,

2) a trend of 2.9% for other medical facilities and providers that are not subject to the Hospital Budget Review.

- For hospitals under the jurisdiction of GMCB, commercial increases approved for 10/1/2020 and 10/1/2021 will mirror those approved 10/1/2019.

- For non-GMCB providers within the broader BCBSVT service area, 2020 and 2021 rate increases are based on 2019 historical rate increases with adjustments made for information learned during any negotiations made prior to the date of filing.

- Unit cost trend reflects a lab re-contracting effort that went into effect 10/1/2019 and is expected to keep lab costs flat through the end of the 2021.

- For providers outside the BCBSVT service area, the Company used the Fall 2019 Blue Trend Survey conducted by the Blue Cross Blue Shield Association.

BCBSVT's analysis resulted in a medical unit cost trend of 3.3% for 2019 and 3.8% for 2020.

MEDICAL UTILIZATION TREND AND INTENSITY

BCBSVT made assumptions regarding future changes to utilization of medical services based on analyzing historical data by benefit category. BCBSVT categorized medical claims into Facility (Inpatient/Outpatient), Professional, and Outpatient Drug categories. Claims data was also adjusted to account for differences between the individual and small group markets, outlier claimants, the age/gender of enrolled members, and changes over time in provider contracted reimbursement rates.

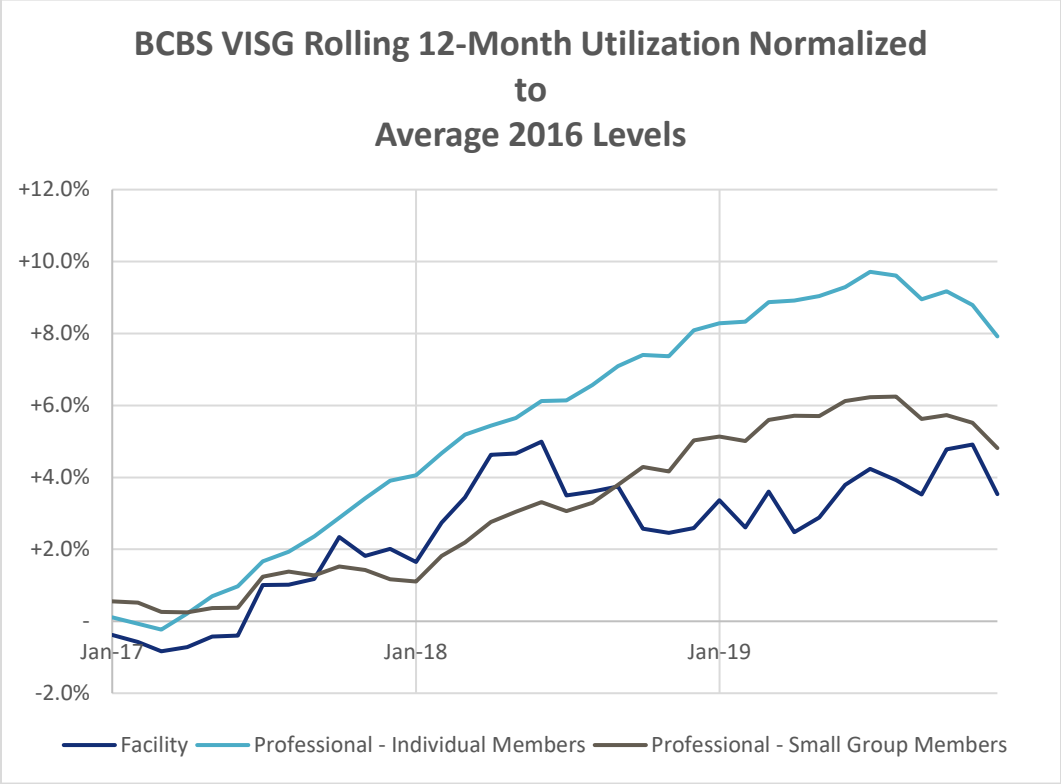
The Company performed common regression and time-series methods to evaluate the utilization and intensity trend over the last several years. Based on this analysis, the Company assumed the following utilization trends:

ASSUMED MEDICAL UTILIZATION TRENDS

Cost Category	2019/2020	2020/2021	2-Year Average
Facility	1.1%	1.1%	1.1%
Professional	1.1%	3.4%	2.3%
Outpatient Drugs	18.5%	18.5%	18.5%
Total Medical	***3.1%***	***4.0%***	***3.6%***

Historical Utilization Patterns

The assumed utilization trends are consistent with the observed average change in utilization over the three-year period from 2016 to 2019, as shown below for facility and professional services. While claims exhibit a common seasonality pattern throughout the calendar year, the average utilization level in 2019 is substantially higher than in 2016.



The following table summarizes the year-over-year change by service category and calendar year of service. Note that the outpatient drug cost category is considered too volatile for the year-over-year utilization trends to be useful for analysis.

YEAR-OVER-YEAR MEDICAL UTILIZATION TRENDS

Cost Category	2017 vs 2016	2018 vs 2017	2019 vs 2018
Facility	2.0%	0.6%	0.9%
Professional – Individual Members	2.7%	3.7%	1.2%
Professional – SG Members	0.7%	3.6%	0.4%

The 2019 utilization trend for professional services fell from the high observed values over the last two years. This suggests that the utilization increases observed in 2017 and 2018 were not necessarily part of a long-term future trend.

The Impact of Population Morbidity on Utilization Trends

To assess utilization trends over time, BCBSVT made several adjustments to historical claims to account for differences across time periods. These adjustments include:

- Changes in provider and unit costs changes.
- Benefit differences.
- Age and gender difference.
- The number of working days in a month, and
- The impact of fraud, waste, and abuse programs.

Due to significant enrollment decreases, BCBSVT accounted for potential morbidity differences in the small group market by analyzing the small groups that had been enrolled continuously since 2015. This restriction was not applied to the individual market. BCBSVT concluded that this restriction was not needed for individuals since observed trends in the individual market were consistent with or lower than trends observed in the small group market.

According to the actuarial memorandum, this methodology "normalizes for changes in population morbidity over time." While it is true that the Company's approach may help limit the fluctuation in population morbidity, L&E does not agree that this approach removes the impact of morbidity changes.

- The Company's reasoning assumes that the population in those groups at the end of the study period would be the same or highly similar to the population at the beginning of the study period. However, L&E notes that the average age factor increased by more than 3.5% during this period, even looking at a fixed set of groups. While BCBSVT accounted for this age change in their analysis, this age change appears to contradict the implicit assertion that the underlying population for the fixed list of small groups is constant enough that further morbidity analysis is unnecessary.

- Most groups can be expected to experience increases or decreases in their average morbidity over time and not stay constant. Since BCBSVT appears to be attracting high-morbidity groups relative to the market (based on risk adjustment transfer payments), it is reasonable to suspect that groups experiencing increases in morbidity have been more likely to stay with BCBSVT than groups experiencing decreases in morbidity.

- The assertion that individual data did not need to be controlled for morbidity changes because "individual market adjusted year over year utilization trends… are consistent with or lower than those for the small group market" is not correct for all service categories. As shown previously, the professional utilization trend for the individual market exceeded the small group trend in all three study years.

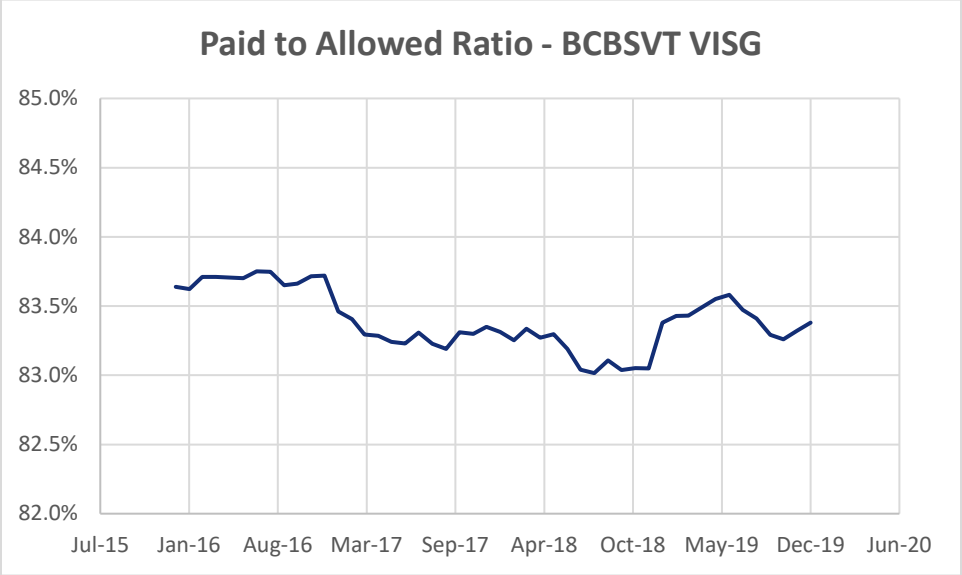
- Moreover, L&E believes that assessing the individual utilization trend just based on the magnitude of the trend relative to the small group market is not sufficient reason to not study possible morbidity adjustments in the individual market.

L&E requested further information to assess the potential impact of population morbidity changes on utilization trends. To the extent that historical cost increases have resulted from population morbidity increases, continuations of those trends would result in increased risk transfer receivables for BCBSVT.

L&E requested that BCBSVT provide historical claims data normalized by plan liability risk scores (PLRS). These risk scores are calculated by the Centers for Medicare and Medicaid Services (CMS) and are used to calculate risk transfer payments.

In response to the request, BCBSVT objected to the use of this data in the development of utilization trends. Therefore, L&E believes it is prudent to reproduce and address BCBSVT's objections before presenting the results of L&E's analysis to provide important context and limitations to the analysis performed.

BCBSVT's first objection to using PLRS-normalized data was that PLRS was designed to estimate paid claims, rather than allowed claims. L&E agrees with this concern in theory, but L&E contends that PLRS is still usable as a proxy for allowed claims especially in light of the fact that the average paid-to-allowed ratio for this block has been quite stable, as shown below:



It is also worth noting that since the paid-to-allowed ratio has decreased slightly over this period, to the extent that the PLRS has increased, it has increased despite decreases in plan liability relative to allowed cost. Therefore, normalizing allowed costs by PLRS would tend to overstate, not understate, trends. However, L&E has chosen to not adjust for this relatively immaterial factor.

BCBSVT's second objection to using PLRS-normalized data was that PLRS is highly sensitive to coding trends. L&E recognizes and agrees with this methodological concern. Due to the impact of coding trends, PLRS-normalized claims cannot be used to establish utilization trends in isolation. However, L&E maintains that PLRS-normalized claims are a useful tool for understanding the range of possible historical trends that are attributable to market-wide utilization increases.

BSBSVT referenced a study by Milliman actuaries which described typical coding trends as being between 1% and 3%. The study also noted that subject to an insurer's coding initiatives, single-year risk score increases could be "in excess of 5%". BCBSVT provided several reasons why coding trend may well have exceeded the typical level on this block in recent years. L&E agrees with BCBSVT that assuming zero coding trend would be inappropriate.

However, the decision not to explicitly consider population morbidity in the development of historical trend estimates implies that the morbidity of groups do not change over time and that all observed changes in PLRS are solely the result of coding efforts. There are several reasons to suspect the observed changes in PLRS are not solely from coding efforts.

- First, BCBSVT has lost approximately 40% of its members in this market over the last five (5) years. As previously discussed, the remaining members have a different age distribution than the members enrolled in 2016 and 2017. Additionally, premium differences between BCBSVT and their competitor can be expected to impact high-cost and low-cost members differently. Members currently receiving treatment for

complicated diseases are less likely to switch carriers than members who are not receiving treatment. Therefore, it is reasonable to expect that a dramatic reduction in market share would create a population with different morbidity characteristics than the population reflected in the earliest years used in the trend analysis.

- Second, utilization increases observed in other Vermont markets (e.g. BCBSVT assumed a 2.0% annual utilization trend in the recently submitted large group filing) and the other VHC carrier have consistently been lower than those exhibited by the BCBSVT VISG block. Therefore, morbidity changes are a likely contributor to utilization increases.

- Third, the coding trend relevant to this analysis is a multi-year trend. While single-year coding increases as high as 5% are not unheard of, the likelihood that this elevated level would be sustained for multiple years is lower.

- Fourth, as noted in the previously mentioned Milliman study, which was used by BCBSVT to support the impact of coding trends, risk scores often exhibit a "spillover" effect. That is, coding trends are experienced not just by the payors engaged in coding initiatives but by the entire market.[5]

  This spillover effect occurs because changes to coding practices occur largely at the provider level, and many providers contract with multiple carriers. L&E believes that a spillover effect could be material in Vermont, since both VHC carriers include virtually all providers in their networks.

  While BCBSVT has exhibited a substantial increase in their PLRS, BCBSVT has also seen substantial increases in risk transfer payments.

HISTORICAL RISK TRANSFER AMOUNTS

Year	BCBS Transfer	BCBS MMs	Transfer PMPM
2016	$275,538	776,768	$0.35
2017	$5,712,124	762388	$7.49
2018	$15,926,267	582,924	$27.32
2019	$20,273,878	481,774	$42.08

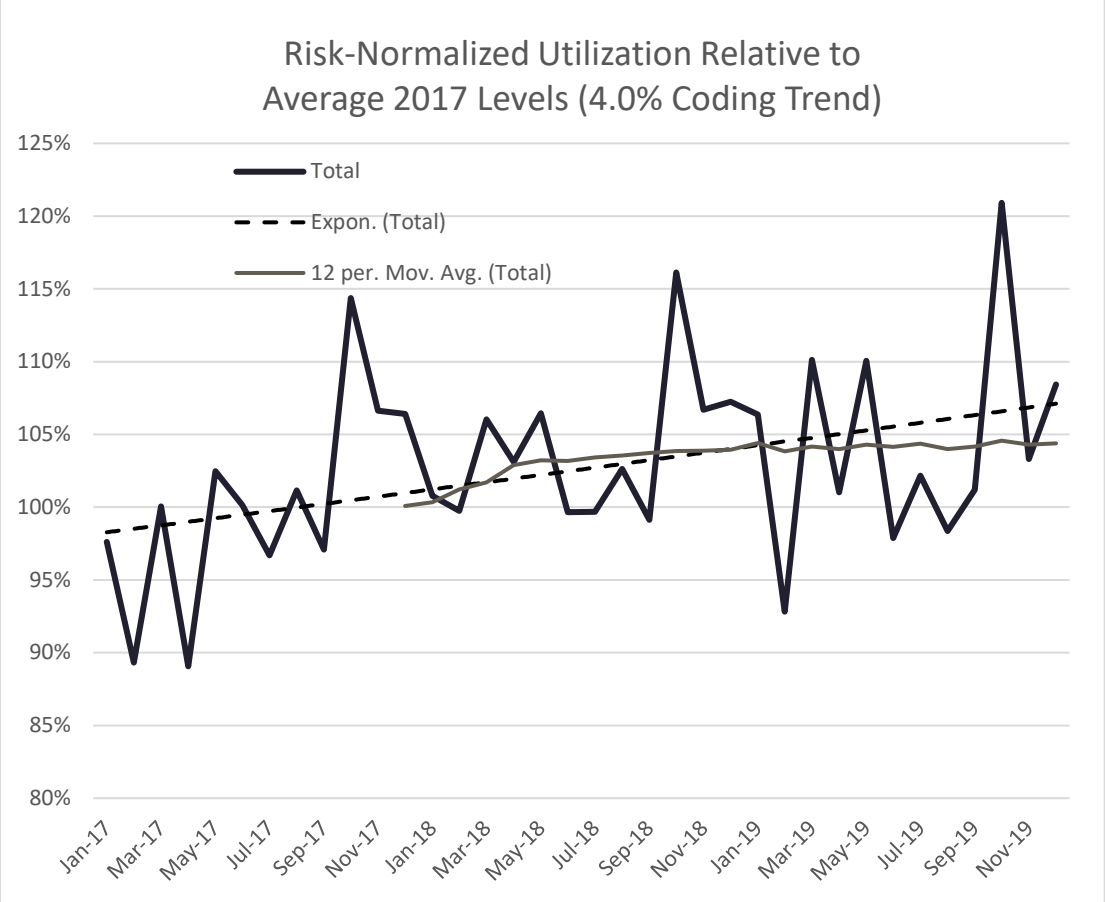
The increases in risk transfer payments suggest that BCBSVT's morbidity profile is increasing rapidly relative to the rest of the market and at a pace that is unlikely to have occurred solely as the result of coding improvements.

[5] https://milliman-cdn.azureedge.net/-/media/products/mara/pdfs/shared-savings-agreements.ashx, page 4

It should be noted that both carriers in the VHC market have a strong economic incentive to constantly strive to improve their coding effectiveness, and any coding trend experienced by the other carrier would act as an offset to BCBSVT's coding trend in the calculation of the transfer payments shown[6].

A transfer of $0 corresponds to having enrolled members who are, on average, as high cost as the entire VISG market. The fact that BCBSVT has gone from an approximate $0 transfer to a transfer which is a material percentage of overall cost suggests that the remaining BCBSVT membership are no longer representative of the market average. Therefore, the observed cost increases are likely attributable to both utilization trend and changes to population morbidity.

BCBSVT's development of utilization trend implicitly assumes that coding trend on this block has averaged approximately 4.6%. While L&E concedes that estimating coding trend is complex, L&E believes that a coding trend of 4.0% would be a more reasonable assumption considering the issues above. The following graph illustrates BCBSVT's risk-normalized utilization assuming an annual coding trend of 4.0%.



[6] A relatively small portion of the increase in transfer amounts PMPM is the increase in market wide average premium. However, this increase is immaterial relative to the magnitude of the observed change in transfers. Additionally, this dynamic is largely offset by the introduction of a 14% reduction to transfer payments in 2018.

Using this 4.0% assumption for coding trend, which is higher than the typical coding trends referenced by BCBSVT, L&E's analysis suggests that the component of observed historical utilization increases attributable to utilization trend (and not morbidity changes) is likely 3.0% per year rather than the proposed average utilization trend of 3.6% (3.1% for 2020 and 4.0% for 2021).

L&E recommends that the total two-year average medical utilization trend assumption be reduced from 3.6% to 3.0%. This change would produce a rate decrease of approximately 0.9%.

TOTAL ALLOWED MEDICAL TREND

Combining the Company's proposed medical annualized unit cost trend of 3.6% with the proposed annualized utilization trend of 3.6% produces an allowed medical trend of 7.3%.

Using L&E's recommended change to utilization trend, the allowed medical trend reduces from 7.3% to 6.7% per year.

If updated information regarding unit cost trends are known at the time of the Board order, L&E recommends considering this updated information in the development of the unit cost assumption underlying the 2021 premium rate calculations. Due to the disruptions from COVID-19, it appears likely that the submitted hospital budget requests will be higher than last year. If this is the case, it may mean that a higher premium increase is necessary.

PHARMACY TREND: The Company is requesting an allowed pharmacy trend of 13.4% per year. This assumption is the same for both 2019 to 2020 and 2020 to 2021.

The Company's approach accounted for pharmacy changes by:

- Adjusting historical experience for changes in benefits and aging population.
- Analyzing cost and utilization trends for Brands, Generics, and Specialty drugs separately, and
- Including the transition of some drugs to generic status which included the resulting unit cost reduction for those drugs.

ASSUMED ANNUALIZED ALLOWED RX TRENDS

Tier	Unit Cost	Utilization	Total Trend	Portion of Rx Spend
Generic	0.25%	3.0%	3.3%	16%
Brand Converting to Generic	-59.7%	3.0%	-58.5%	3%
Brand	10.0%	3.0%	13.3%	32%
Vaccines	20.0%	3.0%	23.6%	1%
OTC	-20.0%	3.0%	-17.6%	1%
Compounds	0.0%	3.0%	3.0%	0%
Specialty[7]	-	-	20.5%	48%
Total	**-**	**-**	***13.4%***	***100%***

The development of the pharmacy trend assumptions was provided in Exhibits 3F through 3I in the initial filing. Exhibit 3F addresses utilization trend for non-specialty drugs. Since members often have a choice of utilizing a brand drug or a generic version of the same compound, the utilization trend is measured in the aggregate across all non-specialty drugs.

BCBSVT used regression analysis on the normalized historical pharmacy claims. As noted in BCBSVT's memorandum, seasonality in the recent claims suggest higher trend increases than an analysis based on a smoothed version of the data. BCBSVT believes that the sharp increase in 4Q2019 costs is unlikely to reflect the pattern of a new long-term trend. Since 4Q2019 heavily influences the regression calculation, recent trends were tempered by longer-term regression results to arrive at a utilization trend assumption of 3.0% per year. L&E finds this modified regression calculation to be reasonable.

The assumed unit cost trend for generic drugs which were already generic in 2019 is 0.25%. This assumption was based on the very slow cost growth observed in recent months. This assumption is consistent with both a 24-month regression estimate and the observed year-over-year increase from CY2018 to CY2019.

Unit cost increases for brand drugs were observed to be 14.1% in 2018 and 9.9% in 2019. BCBSVT elected to reflect the lower value in the assumed future cost increases by assuming a value of 10.0%.

Vaccines and over-the-counter (OTC) drugs make up a very small portion of overall drug costs; however, both have exhibited significant changes in unit costs in recent years. BCBSVT has assumed that vaccines will increase by 20.0% per year and OTC drugs will decrease by 20.0%.

Specialty drug costs are dependent on a relatively small number of very high-cost drugs. Due to the small number of drugs analyzed, BCBSVT elected not to analyze the utilization and unit

[7] Specialty drug cost is projected on a PMPM basis and is not analyzed separately for utilization and unit cost trends. L&E believes this is reasonable.

cost components separately. The following table outlines the last three years of Specialty drug cost trends.

HISTORICAL SPECIALTY RX TRENDS

Year	Individual	Small Group	Combined[8]
2017 vs 2016	38.3%	22.7%	30.5%
2018 vs 2017	32.3%	26.8%	29.5%
2019 vs 2018	15.0%	22.6%	18.6%
3-Year Average	***28.1%***	***24.0%***	***26.1%***

BCBSVT considered several regression and time-series projection methods, which produced estimates similar to historical trend. Based on an analysis of both the historical and modeled trends, BCBSVT assumed a 20.5% per year increase in specialty drug cost.

After reviewing the multiple components of Pharmacy trend, L&E believes that the overall Pharmacy trend assumption of 13.4% appears reasonable and appropriate.

L&E notes that, as with medical trend, some component of historical utilization increases is likely to be the result of changes in population morbidity. However, since drug costs are a relatively small portion of the overall costs modeled by the CMS risk adjustment model, L&E does not believe adjusting drug claims for PLRS would be as applicable as it is for medical claims.

4. CHANGES TO POPULATION MORBIDITY ADJUSTMENT: The Company is estimating that the projected 2021 population morbidity will be 0.3% higher than the 2019 experience period morbidity.

The increase is itemized below:

POPULATION MORBIDITY ADJUSTMENTS

Source of Change	Impact on Morbidity
AHP Impact	-0.2%
Pool Morbidity	+0.5%
Total Morbidity Change	***+0.3%***

The 2020 rates already reflect BCBSVT's prior expectation of 2020 morbidity changes. The final 2020 rates reflected an assumption that morbidity would decrease by 0.8%. Therefore,

[8] The combined trends are normalized for changes in the distribution of small group and individual members.

the rate increase associated with morbidity changes is 1.1% after the realized 2019 changes are considered.

ASSOCIATION HEALTH PLAN (AHP) IMPACT: -0.2%
Pathway 2 AHP's were not allowed to renew coverage for 2020, resulting in some members moving from BCBSVT AHP plans to BCBSVT VISG products during the 2020 open enrollment period. Because these members are now part of the VISG risk pool, BCBSVT calculated the impact of including their 2019 claims in the base period claims for this filing. Since these members had lower claims than existing individual and small group members, adding these members to the VISG risk pool decreased the projected claims by 0.2%. L&E notes that these members were also considered in the 2021 risk adjustment transfer projection, discussed later in this report. L&E believes that the adjustment of projected claims for the known AHP members returning to the VISG market is supported and reasonable.

CHANGES IN POOL MORBIDITY: +0.5%
The claims that underlie the rate filing are from 2019. Since this rate filing was submitted after the 2020 Open Enrollment Period, BCBSVT knows which 2019 members remained in the block and which left.

To assess pool morbidity, the Company separated the 2019 experience into those members who remained in 2020 and those who left in 2020. This includes both individual members who voluntarily cancelled coverage as well as members of groups which are no longer with BCBSVT.

BCBSVT calculated that the members who left BCBSVT in 2020 were lower cost in 2019 than the members that maintained coverage. This enrollment change increases projected claims by 0.5%. As with the AHP change, this claims change is mitigated by the fact that the leaving members take their low risk scores with them. That is, BCBSVT can expect higher risk adjustment receivables resulting from the enrollment change. This impact is discussed in more detail in the Risk Adjustment section of this report.

L&E considers the morbidity adjustments reasonable and appropriate.

COVID-19

The initial rate filing made no explicit adjustments resulting from the COVID-19 pandemic. On July 4, 2020, the Company provided additional documentation detailing a wide variety of scenarios in which the Company estimated the impact of COVID-19. While the Company stressed that the ultimate COVID-19 impact is still highly uncertain, BCBSVT did not propose adding an explicit adjustment to the 2021 VISG rates because of the COVID-19 pandemic.

Based on when the additional information was provided, L&E was unable to perform a full review of the information provided by the time of this report. However, based on an informal review, L&E believes that BCBSVT's analysis included all the variables that needed to be addressed in a COVID-19 modeling.

Based on L&E's cursory review of BCBSVT's documentation, L&E's discussion of COVID-19 impacts in other states, and L&E's involvement with the development of the Society of Actuaries' 2021 Health Care Cost Model, L&E believes that BCBSVT's approach to the COVID-19 pandemic is reasonable.

5. **DEMOGRAPHIC SHIFT:** This factor represents the expected change due to the aging of the population, newborns entering the covered population, and other demographic shifts between 2019 and 2021.

   The Company projects that demographic changes will cause a 0.7% increase in cost over this period. Because last year's filing contained a demographic increase of 3.5%, the update to this assumption creates a 2.7% decrease in 2021 premiums relative to 2020 premiums.

   In the 2020 filing, L&E's review uncovered a methodological problem with how BCBSVT modeled newborns during the coverage year. The method provided in this filing is more detailed than the 2020 method and is documented in Exhibit 2D. The revised methodology appears reasonable and appropriate.

   L&E considers the demographic shift factor to be reasonable and appropriate.

6. **PLAN DESIGN CHANGES:** This factor addresses any rate changes that are needed because members purchase products with different plan designs versus the prior year. BCBSVT expects there to be a change in the average utilization of services due to the expected change in the average cost sharing for the projection period versus the experience period.

   Since members are expected to choose plans with higher cost sharing in 2021 compared to 2019, there is an anticipated decrease in utilization of 0.4%.

   In the prior filing, BCBSVT projected that there would be a shift to richer plans, resulting in a 0.6% increase. Therefore, because the 2021 filing replaces a 0.6% increase with a 0.4% decrease, the net effect relative to current premiums is a 1.0% reduction.

   L&E believes that the plan design adjustment and its calculation are reasonable and appropriate.

7. **CHANGES TO OTHER FACTORS:** BCBSVT expects other changes to account for a 0.9% decrease relative to the prior filing. This reduction is the result of the following factors:

   NON-SYSTEM CLAIMS: -0.5%
   This includes changes to pharmacy rebates, Blueprint payments, Interplan Teleprocessing System (ITS) fees[9], Vaccine payments, and the net cost of reinsurance. The primary driver of this change is the growth in pharmacy rebates that exceed growth in total allowed claims.

   IMPACT OF CAPPING CLAIMS IN HIGH RISK POOL: -0.3%
   Starting in 2020, BCBSVT purchased reinsurance to cover the portion of high-cost claimants which is not already covered by the federal high cost risk pool. These programs are expected to reduce BCBSVT's claims liability by about 0.3%, as demonstrated in the actuarial memorandum.

   L&E does not recommend any changes to the "other" factors described above and finds the assumptions to be reasonable and appropriate.

8. **MANUAL RATE IMPACT:** The Company did not use a manual rate because the 520,581 member months of experience was considered fully statistical credible. L&E considers this to be reasonable and appropriate.

9. **CHANGES DUE TO REINSURANCE:** Expected reinsurance costs/receivables are embedded in other components of the projection and therefore do not result in a separate projection adjustment in this year's filing.

10. **CHANGES TO RISK ADJUSTMENT:** As noted previously, BCBSVT paid more in claims during 2019 than anticipated; however, a portion of this was due to having a higher-morbidity population than in 2018. Therefore, some of the higher claims was offset by an increase in the amount received under the federal Risk Adjustment program. This offset created a 1.4% decrease in the proposed rates.

    BCBSVT projected the 2021 risk adjustment transfer payment based on the most recent data available at the time of the rate filing. The data available was: 1) CMS's interim risk adjustment report[10] published in March 2020, and 2) BCBSVT's internal risk adjustment data. Based on this combined information, BCBSVT estimated that final 2019 risk adjustment receivable would be $20,983,785.

    L&E requested that both VHC carriers provide their Risk Adjustment Transfer Elements Extract (RATEE) reports to compile them confidentially and to provide both carriers with an updated risk adjustment estimate. This calculation indicated that BCBSVT's 2019 risk adjustment receivable would be $20,258,520 for the merged market and $15,359 for the

[9] BCBSVT provides members with healthcare coverage wherever they go across the country and around the world.

[10] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Interim-RA-Report-BY2019.pdf

catastrophic market. This is a total transfer of $20,274,059. This approximate $0.7 million decrease in receivables over BCBSVT's expectations corresponds to approximately a $1.30 PMPM increase in premiums.

L&E recommends revising the risk adjustment calculation such that each carrier begins with the same 2019 value. Therefore, L&E recommends that each company use a 2019 risk adjustment transfer payment estimate of $20,274,059. If CMS releases final 2019 transfer amounts prior to final rate approval and they differ from L&E's calculations, L&E recommends that the CMS numbers be used.

BCBSVT also considered the impact on risk adjustment resulting from population changes between 2019 and 2021. The Company's population adjustments appear consistent with the way projected claims were developed. That is, the Company accounted for members and groups known to have left BCBSVT based on their 2020 enrollment status. L&E believes this calculation to be reasonable and appropriate.

BCBSVT originally projected a 2021 risk adjustment receivable of $65.44. L&E recommends that the final risk adjustment estimate should be reduced to approximately $64.10 to account for the data that was not available at the time of filing. This would result in an approximate 0.2% increase to 2021 premiums relative to the current filing.

11. **CHANGES IN EXCHANGE USER FEES:** This is not applicable to Vermont in 2021, as Vermont operates its own Exchange and does not charge users a fee.

12. **CHANGES IN ACTUARIAL VALUE:** The increase in the Actuarial Value (AV) assumption is 1.8% relative to the 2020 filing. This reflects Pricing AV changes such as changes in Metal AVs and changes in the projected enrollment distribution by plan.

    During the review of the 2020 rate filing L&E recommended that the AV assumptions should include the anticipated average effect of correlation between allowed cost and Actuarial Value. L&E notes this effect has intensified since 2020, as documented in Exhibit 6E. This assumption appears to be the primary driver for the expected factor change. L&E believes the paid-to-allowed ratios and pricing AVs appear reasonable and appropriate.

13. **CHANGES IN ADMINISTRATIVE COSTS:** PMPM administrative costs are projected to increase by about 14% compared to the prior filing. Because administrative costs are a relatively small portion of the premium and the fact that claims are also expected to increase relative to the prior filing, the change in administrative costs are expected to increase 2021 premiums by approximately 1.0%.

    The 2021 projected administrative cost differs from the approved 2020 administrative cost for the following reasons:

    - *Updated Base Period Cost:* The base period cost PMPM increased by 5.4% between 2018 and 2019, due largely to decreases in enrollment.

- *Investment costs related to VHC Billing in 2022:* Responsibility for billing VHC enrollees will be transferred to participating carriers in 2022. In preparation for this responsibility, BCBSVT is incurring costs to develop the systems necessary to bill VHS enrollees. BCBSVT estimated these 2021 costs to be $0.94 PMPM, or about $430,000.

- *Credit Card Fees:* BCBSVT will begin allowing off-Exchange members to pay premiums with debit and credit cards. They anticipate that associated fees will amount to 2.3% of premiums paid in this manner. Non-Exchange members will continue to pay premiums through VHC until 2021. It was discovered that all VHC members were not properly considered in the original calculation. BCBSVT revised the calculation and acknowledged that the rates should be reduced by approximately 0.2%. L&E agrees with this change.

In addition to reviewing each of the specific modifications proposed by BCBSVT, L&E also compared BCBSVT's administrative costs for the individual and small group markets to other nationwide BCBS plans. The comparison was based on a review of the 2019 National Association of Insurance Commissioners (NAIC) Annual Statements.

BCBSVT's administrative costs on a percentage of premium basis ranked 57th out of 62 plans assessed. That is, on a percentage of premium basis, BCBSVT had lower expenses than approximately 90% of the Blues plans who sold individual and small group products.

BCBSVT's administrative costs on a PMPM basis ranked 52nd out of 62 plans assessed. That is, BCBSVT had lower PMPM expenses than approximately 82% of Blues plans.

L&E considers the revised expense assumptions to be reasonable and appropriate.

14. **CHANGES IN TAXES & FEES:** The total taxes and fees provision decreased from 3.5% in 2020 to 1.4% in 2021 due to the federal Health Insurer Fee being waived for 2021. The other taxes consist of GMCB billbacks, the Health Care Claims Tax, the Risk Adjustment User Fee, and the Patient Centered Outcomes Research Institute Fee. The change in taxes and fees decreases the premium by 2.4%.[11] L&E considers the proposed changes in taxes and fees to be reasonable and appropriate.

    The URRT that was originally submitted with this filing incorrectly reported last year's taxes and fees. The URRT has been corrected with no impact to premiums.

15. **CHANGES IN CONTRIBUTION TO RESERVES:** The Company has proposed an aggregate contribution to reserve (CTR) of 1.8% which consists of: 1) a base CTR of 1.5%, which is consistent with the requested CTR in the prior filing, and 2) an additional 0.3% to account for uncollected premiums and bad debt.

[11] The reason that the rate impact is greater than the difference between the 2019 and 2020 assumptions is that all non-claims rate components are treated as fixed percentages of premium within this report. The difference between the 2020 and 2021 tax assumptions is leveraged over the traditional loss ratio to arrive at the 2.4% premium impact.

The table below shows the actual historical CTR and the expected CTR based on the Company's forecasting model, which incorporates final premiums, including modifications ordered by the Board. L&E believes that the results demonstrate that BCBSVT has successfully projected future results based on the information available at the time final rates are approved the Board.

ACTUAL-TO-EXPECTED CTR

Year	Company Expected	Company Actual
2014	-0.1%	1.0%
2015	1.0%	-1.4%
2016	0.8%	-3.8%
2017	1.0%	1.0%
2018	-3.8%	-3.4%
2019	0.0%	-0.4%
Average	***-0.2%***	***-1.4%***

As a reasonableness check of the proposed CTR provision, L&E reviewed the Center for Consumer Information & Insurance Oversight (CCIIO) public use files (PUFs). In 2020, there were 783 QHP Filings (individual and small group combined) filed across the country. Across the 783 filings, the average submitted CTR was 3.45% and the median submitted CTR was 3.24%. Based on the 2020 filings, an assumed base CTR of 1.5% would rank 630th out of the 783 filings. That is, over 80% of the filings had assumed CTRs higher than 1.5%. In 2019, over 82% of the filings had assumed CTRs higher than 1.5%. In 2018, over 79% of the filings had assumed CTRs higher than 1.5%.

In addition to reviewing the CTR assumption relative to other QHP insurers, L&E reviewed BCBSVT's capital and surplus position based on several metrics compared to 65 Blues plans based on information provided in the 2019 NAIC Annual Statements.

The first metric was the Company's Risk Based Capital (RBC)[12] percentage relative to other BCBS plans. BCBSVT's actual 2019 RBC percentage is ranked 53rd out of 64 insurers with available data.

Of these 64 plans, the average RBC percentage was approximately 867% and the median RBC percentage was approximately 770%. This implies that BCBSVT's current target RBC range of 590% to 745% falls in the bottom half of actual RBCs for nationwide BCBS plans. That is, over half of the Blues plans had actual RBCs higher than the BCBSVT's targeted maximum.

The second capital and surplus metric assessed was how much surplus was held on a PMPM basis.

[12] "Risk-Based Capital" is a framework that helps measure the potential of an insurer becoming insolvent. A low RBC can indicate a high risk of an insurer becoming unable to meet its financial obligations.

At the end of 2019, BCBSVT held $56.37 PMPM of surplus. This value ranked 54th of 63 Blues plans with available data. BCBSVT's surplus PMPM was less than half of the median value of $124.15 PMPM.

The third capital and surplus metric assessed was how much surplus was held as a percentage of premium. At the end of 2019, BCBSVT held 24.8% of premium as capital and surplus. This value ranked 47th of 64 Blues plans. BCBSVT's surplus as percentage of premium was significantly lower than the median value of 38.9%.

The fourth capital and surplus metric assessed how much surplus the Company held relative to the number of months of claims could be paid out to members. At the end of 2019, BCBSVT held 3.2 months of claims as surplus. This value ranked 51st out of 65 Blues plans. BCBSVT's 3.2 months of claims was significantly lower than the median value of 5.4 months.

Since the filing of the 2019 Annual Statement, BCBSVT's capital and surplus position has been impacted in several material ways. These impacts include, but are not limited to:

EXPECTED POSITIVE IMPACTS TO RBC

- Deferred or eliminated care due to the COVID-19 pandemic.
- Remaining Cares Act AMT credit refunds.
- Litigation recovery from Risk Corridor judgment.

EXPECTED NEGATIVE IMPACTS TO RBC

- The Company experienced a substantial loss of asset value in its pension benefit obligations (PBO).
- Equity market losses on the asset portfolio supporting its insurance liabilities.
- Increased uncollected premiums and response costs resulting from COVID-19.

At the time of this report, L&E did not have enough information to fully evaluate the short-term and long-term net impacts of the above 2020 issues. However, based on early indications regarding the PBO losses, the COVID-19 costs incurred to date, and the significant uncertainty surrounding future COVD-19 impacts, it appears that the Company's RBC could fall below its targeted level of 590% by the end of 2020. Therefore, L&E recommends that the Board take this into consideration when evaluating BCBVT's CTR provision. Additionally, L&E recommends that any solvency analysis performed by the Department of Financial Regulation around these issues be strongly considered.

As stated previously, due to the required grace period under the Affordable Care Act, the Company included an additional risk margin provision for bad debt of 0.3% to pay for the claims for members for which premiums are never collected. The average amount of non-paid premiums due to the grace period provision over the last several years was 0.1%.

The increase of 0.2% in the bad debt assumption reflects the inclusion of outstanding receivables that are not related to the 30-day grace period. BCBSVT has stated that these costs were paid by VHC through 2016 through a settlement process but cited incurred costs from 2017 to 2019 as a

basis for increasing rates this year. In both 2018 and 2019 these unpaid amounts amounted to 0.2% of billed premium.

L&E believes the CTR assumption is reasonable and does not recommend any changes to the CTR.

16. **CHANGES IN SINGLE CONTRACT CONVERSION FACTOR:** A conversion factor[13] adjustment is used to convert and allocate the gross claim costs to premiums based on state-mandated tier factors. The single conversion factor is decreasing by 0.2% from the prior filing, resulting in a 0.2% decrease in rates. This corresponds roughly to a slight decrease in the number of covered children per policy and is based on actual membership data emerging in 2020. This is considered reasonable and appropriate.

RECOMMENDATIONS

After modification, L&E believes that this filing does not produce rates that are excessive, inadequate, or unfairly discriminatory. Therefore, L&E recommends that the Board make the following modifications:

- **WEIGHTED AVERAGE TREND CORRECTION:** Reflect the correct trend weighting in the development of the projected index rate. This results in an increase of 0.12% to the filed premium rates.

- **CORRECT URRT RETENTION ITEMS:** Correct reporting of non-claims items in the URRT. This has no impact on filed rates.

- **CONSIDER UPDATED HOSPITAL BUDGET INFORMATION:** If updated information regarding unit cost trends are known at the time of the Board order, L&E recommends updating the assumed unit cost trends in the 2021 premium rate calculations. The impact of such a change cannot be estimated at this time.

- **REDUCE UTILIZATION TREND:** Reduce the utilization trend for medical services such that the average annual utilization trend is 3.0% rather than the current 3.6%. This results in a decrease to filed premiums of approximately 0.9%.

- **UPDATE RISK ADJUSTMENT:** L&E recommends that the projected risk adjustment receivable be changed to reflect L&E's estimate of the 2019 risk transfers. This will increase rates by approximately 0.2%. If L&E's estimate does not ultimately agree with CMS' final published transfers, the CMS values should be used in the rate increase calculation instead.

[13] The conversion factor adjusts the premium that is developed on a PMPM basis to be on a tiered basis. This adjustment is necessary because the premium on a PMPM basis is an average over all adults and children. However, Vermont's tiered premiums require the base premium to be for a single adult.

- **CORRECT CREDIT CARD FEES:** Remove credit card fees for VHC members. This will reduce premiums by about 0.2%.

After the modifications, the anticipated overall rate increase will reduce from 6.3% to approximately 5.5%.[14]

2021 RECOMMENDED RATE CHANGES

Metal Tier	BCBSVT Proposed Rate Change	L&E Recommended Rate Change	Percent of Membership
Catastrophic	-0.7%	-1.4%	1%
Bronze	4.3%	3.5%	16%
Silver Loaded	5.6%	4.8%	15%
Silver Reflective	4.9%	4.1%	20%
Gold	8.5%	7.7%	28%
Platinum	6.6%	5.8%	20%
Overall	***6.3%***	***5.5%***	***100%***

[14] Due to the complexity of the premium rate development and the possible interdependency of the assumptions modified, the actual implemented rate change may vary from the estimate.

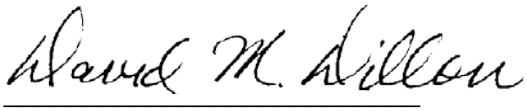
A breakdown of L&E's recommendation by rating component is provided below:

COMPONENTS OF 2021 RECOMMENDED RATE INCREASE

Rating Component	Filed Change	L&E Recommendation
1. 2019 Actual/Projected Claims Experience	1.9%	No change
2. Difference in Trend from 2019 to 2020	0.3%	0.2%
3. Trend from 2020 to 2021	8.9%	8.1%
4. Changes to Population Morbidity Adjustment	1.1%	No change
5. Demographic Shift	-2.7%	No change
6. Plan Design Changes	-1.0%	No change
7. Changes to Other Factors	-0.9%	No change
8. Manual Rate Impact	0.0%	No change
9. Changes due to Reinsurance	0.0%	No change
10. Changes to Risk Adjustment	-1.4%	-1.2%
11. Changes in Exchange User Fees	0.0%	No change
12. Changes in Actuarial Value	1.8%	No change
13. Changes in Administrative Costs	1.0%	0.8%
14. Changes in Taxes & Fees	-2.4%	No change
15. Changes in Contribution to Reserves	0.2%	No change
16. Changes in Single Contract Conversion Factor	-0.2%	No change
Total Rate Change	**+6.3%**	**+5.5%**

Sincerely,

Kevin Ruggeberg, ASA, MAAA
Consulting Actuary
Lewis & Ellis, Inc.



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Vice President & Principal
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ASOP 41 DISCLOSURES

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[15], promulgates Actuarial Standards of Practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct[16], to observe the ASOPs of the ASB when practicing in the United States. ASOP #41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in the following.

IDENTIFICATION OF THE RESPONSIBLE ACTUARIES

The responsible actuaries are:

- Kevin Ruggeberg, ASA, MAAA, Consulting Actuary.
- David M. Dillon, FSA, MAAA, MS, Senior Vice President & Principal.
- Jacqueline B. Lee, FSA, MAAA, Vice President & Principal.

IDENTIFICATION OF ACTUARIAL DOCUMENTS

The date of this document is July 7, 2020. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is July 4, 2020.

DISCLOSURES IN ACTUARIAL REPORTS

- The contents of this report are intended for the use of the Green Mountain Care Board. The authors of this report are aware that it will be distributed to third parties. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.

- Lewis & Ellis is financially and organizationally independent from BCBSVT. L&E is not aware of anything that would impair or seem to impair the objectivity of the work.

- The purpose of this report is to assist the Board in assessing whether to approve, modify, or disapprove the rate filing.

- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.

- Lewis & Ellis has reviewed the data provided by BCBSVT for reasonableness; however, not every aspect of the data has been audited. Neither L&E, nor the responsible actuaries, assume responsibility for the items that may have a material impact on the analysis. To the extent that there are material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.

[15] The American Academy of Actuaries (Academy), the American Society of Pension Professionals and Actuaries, the Casualty Actuarial Society, the Conference of Consulting Actuaries, and the Society of Actuaries.

[16] These organizations adopted identical *Codes of Professional Conduct* effective January 1, 2001.

- Notwithstanding the ongoing COIVD-19 pandemic, L&E is not aware of any subsequent events that may have a material effect on the findings.

- There are no other documents or files that accompany this report.

ACTUARIAL FINDINGS
The actuarial findings of the report can be found in the body of this report.

METHODS, PROCEDURES, ASSUMPTIONS, AND DATA
The methods, procedures, assumptions, and data used by the actuaries can be found in body of this report.

ASSUMPTIONS OR METHODS PRESCRIBED BY LAW
This report was prepared as prescribed by applicable law, statues, regulations, and other legally binding authority.

RESPONSIBILITY FOR ASSUMPTIONS AND METHODS
The actuaries do not disclaim responsibility for material assumptions or methods.

DEVIATION FROM THE GUIDANCE OF AN ASOP
The actuaries have not deviated materially from the guidance set forth in the applicable ASOPs.